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8	BEFORE THE BOARD OF REGISTERED NURSING
9	DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA
10	
11	In the Matter of the Accusation Against: Case No. 2013-971
12	DEBORA WILKINSON PAUTSCH
13	338 Legion Avenue Chico, CA 95926 A C C U S A T I O N
14	Registered Nurse License No. 245224
15	Public Health Nurse Certificate No. 20158
16	Respondent.
17	Complainant alleges:
18	PARTIES/LICENSE INFORMATION
19	1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
20	official capacity as the Executive Officer of the Board of Registered Nursing ("Board"),
21	Department of Consumer Affairs.
22	2. On or about August 31, 1974, the Board issued Registered Nurse License Number
23	245224 to Debora Wilkinson Pautsch ("Respondent"). Respondent's registered nurse license was
24	in full force and effect at all times relevant to the charges brought herein and will expire on
25	January 31, 2014, unless renewed.
26	3. On or about October 18, 1974, the Board issued Public Health Nurse Certificate
27	Number 20158 to Respondent. Respondent's public health nurse certificate was in full force and
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#### **COST RECOVERY**

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

### FIRST CAUSE FOR DISCIPLINE

## (Gross Negligence)

- 10. At all times relevant to the charges brought herein, Respondent was employed as a registered nurse by California Forensic Medical Group, Inc. and worked at the Butte County Jail located in Oroville, California.
- On or about August 31, 2006, at approximately 0635 hours, A.S., a 56 year old male, 11. was brought into the jail by correctional officers. A.S. was shackled behind his back, was in a prone position, and had defecated on himself. At approximately 0640 hours, Respondent performed a pre-screening medical evaluation on A.S. as the officers held him face down. One of the officers was applying pressure on A.S.'s legs, having crossed them and pushed them down over and onto his buttocks. As Respondent began her initial assessment, A.S.'s lower extremities had become lax, he was incontinent of urine, and had no further movement. Respondent was unable to obtain A.S.'s blood pressure due to his restrained position. Respondent signed off on the Medical Pre-Screening form, indicating that A.S. was cleared to enter the jail and be placed in a sobering cell. The officers carried A.S. beyond the sally port and into the jail still in a prone position. A.S.'s head was hanging down unsupported and his arms and legs were flaccid. After placing A.S. into the sobering cell, the officers began removing his belt and shoes. A few minutes later, A.S. was turned over onto his back. The officers then discovered that A.S. was without a pulse and not breathing. Respondent was called to the sobering cell and found A.S. nonresponsive. Respondent began CPR and "911" was called. At approximately 0651 hours, Fire Department personnel took over CPR. At approximately 0651 hours, paramedics arrived,

applied a monitor to A.S., intubated him, and placed him on a back board. At approximately 0703 hours, A.S. was transported to Oroville Hospital. A toxicology screening was performed on A.S. which was positive for cocaine, marijuana, and alcohol. The initial diagnosis was likely polysubstance binge-triggered MI (myocardial infarction) and brain death.

- 12. On or about September 1, 2006, A.S. was transferred to Kaiser North Valley Hospital located in Sacramento, California. A.S. died on September 2, 2006. The Sacramento County Coroner reported A.S.'s cause of death as anoxic/ischemic encephalopathy due to sudden cardiac arrest while being restrained prone by the correctional officers, excited delirium syndrome, and acute combined cocaine and ethanol intoxication.
- 13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about August 31, 2006, Respondent was guilty of gross negligence in her care of A.S. within the meaning of Regulation 1442, as follows:
- a. Respondent failed to conduct a thorough assessment of A.S. in the sally port and allowed him to enter the jail without a documented blood pressure and without evaluating his level of consciousness or assessing his pupils.
- b. Respondent failed to recognize that A.S. was in a compromised medical condition upon his arrival in the sally port, and failed to refer him to the local emergency room.
- c. Respondent failed to provide appropriate CPR to A.S. in that she failed to assure or secure ventilation with an airway, failed to call for an Ambu bag and oxygen equipment even though those medical supplies or equipment were available at the jail, and failed to direct 30:2 chest compressions to ventilation despite the fact that she was recently recertified in basic CPR.

## SECOND CAUSE FOR DISCIPLINE

## (Incompetence)

14. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 10 through 12 above.

<sup>&</sup>lt;sup>1</sup> Respondent was recertified in basic CPI on May 23, 2006.

Revoking or suspending Registered Nurse License Number 245224, issued to Debora

Respondent is subject to disciplinary action pursuant to Code section 2761,

- Revoking or suspending Public Health Nurse Certificate Number 20158, issued to
- Ordering Debora Wilkinson Pautsch to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and
  - Taking such other and further action as deemed necessary and proper.